MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10185

Reg. Dist. No. 203

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Kent

City or town: Rock Hall Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? life

Hospital, institution, or street address where death occurred: —

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Kent

City or town: Rock Hall Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Sharp Town

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Mary Marie Gaines

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
fem	col	single

6.(b) Name of husband or wife: —

6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): June 21 1945

8. AGE:

Years	Months	Days	If less than one day
	3	19	....hrs. ....min.

9. Birthplace: Rock Hall, Md (Town, county, and state)

10. Usual occupation: —

11. Industry or business: —

FATHER

12. Name: Wm McKinley Gaines

13. Birthplace: Rock Hall

MOTHER

14. Maiden name: Mary Eliz Hynson

15. Birthplace: Rock Hall, Md

16. Informant: Wm Mc Gaines

Address: Rock Hall, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 11 1945 (month) (day) (year)

Cemetery or ~~crematory~~: Sharp Town.

Location: Rock Hall Md.

18. Funeral director: Asbury Henry

Address: Georgetown P.O Chestertown, Md

19. 10/11 1945 S. Elwood Burgard (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 10 1945, at 5:00 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 6 1945, to Oct 10 1945 and that I last saw h.. alive on 10-6. 1945

Immediate cause of death	DURATION
malnutrition	
Due to: Gastro-Enteritis	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: — Date of op.: —

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: — Date of: —

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): —

Means of injury: — Injured at work? —

23. SIGNATURE: Elwood Burgard M. D. or ~~other~~

Address: Rock Hall, Md Date signed: 10/10/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1340)

CERTIFICATE OF DEATH

10186

Reg. Dist. No. 202

1. PLACE OF DEATH:

County: Kent

City or town: Lynch
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Kent

City or town: Lynch
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Catharine Price Goodman

3.(b) Social Security Number: 220-16-9871

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Married

6.(b) Name of husband or wife: Roy Goodman

6.(c) If alive, give age: 48 years

7. Birth date of deceased (mo., day, yr.): July, 26 1897

8. AGE:	Years	Months	Days	If less than one day
	48	2	20	...hrs. ...min.

9. Birthplace: Millington, Kent Co., Md.
(Town, county, and state)

10. Usual occupation: housewife

11. Industry or business: home

FATHER
12. Name: Lewis S. Price
13. Birthplace: Millington, Md.

MOTHER
14. Maiden name: Ida Moore
15. Birthplace: Galena, Kent Co., Md.

16. Informant: Mr. Roy Goodman
Address: Lynch, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 19, 1945 (month) (day) (year)

Cemetery or crematory: Chester

Location: Chestertown, Md.

18. Funeral director: Marvin V. Williams

Address: Chestertown, Md.

19. Oct. 18, 1945 (Date rec'd by registrar) Clara S. Barnes. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 16 1945, at 10:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 20 1945 to Oct 16 1945

and that I last saw h... alive on Oct 16 1945

	DURATION
Immediate cause of death: Coma	1 Day
Due to: Pyelonephritis	5 weeks
Due to: Renal Calculus	2
	1
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: H. G. Simpers M. D. or other

Address: Chestertown Date signed 10-17-45

M

MARGIN RESERVED FOR BINDING

I

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21)

CERTIFICATE OF DEATH

10183 Dr Smith

Reg. Dist. No. 201

1. PLACE OF DEATH:
County: Kent
City or town: Worton, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Kent
City or town: Worton Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No.: main St
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Cornelius Gibson Hadaway

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	W	Widower

6.(b) Name of husband or wife: Mrs Sallie Hadaway
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): apr 5 1853

8. AGE: Years: 92 Months: 6 Days: 13 If less than one day: hrs. min.

9. Birthplace: Cliff City Chestertown Md RFD (Town, county, and state)
10. Usual occupation: Retired
11. Industry or business: Farm

FATHER
12. Name: Robert Hadaway
13. Birthplace: Maryland.

MOTHER
14. Maiden name:
15. Birthplace: Maryland

16. Informant: Frank N. Hadaway
Address: Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 20 1945 (month) (day) (year)
Cemetery or crematory: Chester Cemetery
Location: Chestertown, Md.
18. Funeral director: C R Fellows
Address: Still Pond Md.

19. Oct 19 1945 (Date rec'd by registrar) J H Clark Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 18 1945, at 4:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1946, to Oct 17 1945
and that I last saw him alive on Oct 17 1945

Immediate cause of death	DURATION
Chronic Myocarditis	1940
Due to	
Due to	
Other conditions: Pts. Blindness	1942

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Frank N. Smith M. D. or other
Address: Chestertown Date signed: 10/19/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (26)

CERTIFICATE OF DEATH

10188

★ Reg. Dist. No. 200

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
County Kent
City or town Millington Md.
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days) none
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County
City or town Millington Md. Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. R.F.D.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Eva Johnson.

3. (b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Fem	Colored	married

6 (b) Name of husband or wife Mr Samuel Johnson
6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 10 1892

8. AGE: Years	Months	Days	If less than one day
53			hrs. min.

9. Birthplace Md.
(Town, county, and state)
10. Usual occupation House Wife
11. Industry or business
FATHER 12. Name John Crosbery.
FATHER 13. Birthplace Md.
MOTHER 14. Maiden name Rosey Fontain
MOTHER 15. Birthplace Md.
16. Informant Samuel Johnson.
Address Millington Md. R.F.D.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 5 1945 (month) (day) (year)
Cemetery or crematory Graves Cemet
Location Near Millington Md.
18. Funeral director Calvin Lelans
Address 102 to Green st Del.
19. Nov 2 (Date rec'd by registrar) 19 45 Edward Kellum Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 31 19 45, at 9 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 19 45, to Oct 31 19 45, and that I last saw h-- alive on Oct 26 19 45.

Immediate cause of death Acute Cardiac Dilation — DURATION
Due to Chronic Hypertension
Due to Arterial Arteriosclerosis
Other conditions
(Include pregnancy within 3 months of death)
Major findings:
Of operations —
Of autopsy —

PHYSICIAN Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of
Where did injury occur? — (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work? —

23. SIGNATURE C. W. Upthegrove M. D. or other
Address Centreville Md Date signed 11/1/45

VS A15

10189

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (23d)

CERTIFICATE OF DEATH

Reg. Dist. No. 202

1. PLACE OF DEATH:
County: Kent
City or town: Chestertown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? all Life
Hospital, institution, or street address where death occurred:
How long in hospital or institution? ******

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Kent
City or town: Chestertown
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: John Thomas Richardson

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Col.	Married

6.(b) Name of husband or wife: Georgianna Richardson
6.(c) If alive, give age: 60 years

7. Birth date of deceased (mo., day, yr.): March 21.1876

8. AGE: Years	Months	Days	If less than one day
69	7	3	hrs. min.

9. Birthplace: Chestertown Kent Co Md.
(Town, county, and state)

10. Usual occupation: Laborer(Fertilizer Ind.)
11. Industry or business: Fertilizer Industry

FATHER
12. Name: John Richardson
13. Birthplace: Kent Co Md.

MOTHER
14. Maiden name: Georgianna Griffin
15. Birthplace: Del.

16. Informant: Georgianna Richardson (Wife)
Address: Chestertown Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 27 1945 (month) (day) (year)
Cemetery or crematory: Chestertown Md
Location: Chestertown
18. Funeral director: Asbury Henry
Address: ~~209 Lynchburg Street~~ Chestertown
19. (Date rec'd by registrar) Oct. 27-1945 Registrar: Clara S. Barnes.

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 24.1945 at 4 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19; and that I last saw him alive on 19. Did not attend Investigated death and signed certificate as Deputy Med. Exam.

	DURATION No. Yrs.
Immediate cause of death: Myocarditis	
Due to: Ateriosclerosis	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: None
Date of op.
Autopsy results: None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: No Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Deputy Medical Exam. Kent Co Md.
Address: Chestertown Md. M. D. or other
Date signed: 10.24.5

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83)

10190

CERTIFICATE OF DEATH

Reg. Dist. No. 20

1. PLACE OF DEATH:
County: Kent
City or town: Millington
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Kent
City or town: Millington
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Julia E. Robinson

3. (b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Alfred Robinson
6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): Sept 23 1886

8. AGE: Years: 59 | Months | Days | If less than one day: ____ hrs. ____ min.

9. Birthplace: Queen Anne Md.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER
12. Name: John Dixon
13. Birthplace: Md.

MOTHER
14. Maiden name: Annie
15. Birthplace: Md

16. Informant: Alfred Robinson
Address: Millington Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 31 1945 (month) (day) (year)
Cemetery or crematory: Millington
Location: Millington Md.

18. Funeral director: Edward Fellows
Address: Millington Md.

19. Oct. 31 1945 (Date rec'd by registrar) Edw. Fellows. Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 27, 1945, at 1 2 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 26 1945 to Oct 27 1945 and that I last saw h[illegible] alive on Oct 26 1945

Immediate cause of death	DURATION
Apoplexy	4 Hrs
Due to: Hypertension	2 yr
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: G. L. Copeland M. D. or other
Address: Millington Date signed Oct 31 45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (134-6)

CERTIFICATE OF DEATH

10191 201

Reg. Dist. No.

1. PLACE OF DEATH:

County: Kent

City or town: Worton Md Colemans Rural
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 40 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Kent

City or town: Rural Worton Md
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Worton Md
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Charles Taylor

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	C	Married

6.(b) Name of husband or wife: Ardella Taylor

6.(c) If alive, give age: 80 years

7. Birth date of deceased (mo., day, yr.): aug 12 1876

8. AGE:

Years	Months	Days	If less than one day
69	1	21	...hrs. ...min.

9. Birthplace: Kent Co Md
(Town, county, and state)

10. Usual occupation: Farm work

11. Industry or business: Farm

FATHER
12. Name: John Taylor
13. Birthplace: Maryland

MOTHER
14. Maiden name: unknown
15. Birthplace: " "

16. Informant: Mervin L Taylor
Address: Worton Md Rural

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 6 1945 (month) (day) (year)

Cemetery or crematory: Colemans

Location: Colemans Worton Md Rural

16. Funeral director: B R Fellows

Address: Still Pond Md

19. Oct 6 1945 (Date rec'd by registrar)

J M Clark Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 3 1945 at 5 A.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 27 1945 to Oct 1 1945 and that I last saw him alive on Oct 1 1945

Immediate cause of death	DURATION
Cause Nephritis	1 day
Due to: Hypertension Arteriosclerosis	10 yrs
Due to:	
Other conditions: Uremia	3 days

(Include pregnancy within 3 months of death)

Major findings of operations: ...Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ...Date of:

Where did injury occur? (City or town) (County) (State)

(Specify home, farm, industry, public place (where?):

Means of injury: ...Injured at work?

23. SIGNATURE: Ira L Smith M. D. or other

Address: Chestertown Date signed: 10/4/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

Evidence for the change of age is shown on Film G 99 11/21/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

10192

CERTIFICATE OF DEATH

Reg. Dist. No. 201

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
County: Kent
City or town: Worton Md Rural Fountain
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: —
Stay in hospital or Inst. (yrs., or mos., or days): —
Stay in this community (yrs., or mos., or days): all his life.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Kent
City or town: Rural Worton Md Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: Worton Md
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR: —

3. (a) FULL NAME: Hiram J Wallace

3. (b) Social Security Number: 215-20-7548

4. Sex: M
5. Color or race: C
6. (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or wife: Lelia Wallace
6 (c) If alive, give age: 54 years
7. Birth date of deceased (mo., day, yr.): Nov 17 1885
8. AGE: Years 61 (59) Months 0 Days 29 If less than one day ___ hrs. ___ min.
9. Birthplace: Worton Md Fountain Rural
(Town, county, and state)
10. Usual occupation: Farm work
11. Industry or business: Farm

FATHER
12. Name: John Henry Wallace
13. Birthplace: Kent Co Maryland

MOTHER
14. Maiden name: Everline Anderson
15. Birthplace: Kent Co Maryland.

16. Informant: Lelia Wallace
Address: Worton Md Fountain Rural
17. Burial Date thereof: Oct 26 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory: Fountain Rural Worton Md
Location: Worton Md Rural.
18. Funeral director: B K Fellows
Address: Still Pond Md
19. Oct 25 1945 J B Clark
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 21 1945, at 7 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ___ 19__ to ___ 19__ and that I last saw him alive on ___ 19__
Did not attend — death certificate signed by Dep. Med. Exam. — Heart
Immediate cause of death: Coronary
DURATION: Minutes
Due to: Thrombosis
Angina
Due to: Arterio sclerosis
Other conditions: No 7 yrs
(Include pregnancy within 3 months of death)
Major findings:
Of operations: None
Of autopsy: No

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: No Date of
Where did injury occur?: None
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ___ Injured at work?
Frank Hines M D
Dep. Med. Exam. Kent Co
23. SIGNATURE ___ M. D. or other
Address: Chestertown Md Date signed: Oct 21/45

VS A15

10193

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (170-C)

CERTIFICATE OF DEATH

Reg. Dist. No. 202

Kent Co

1. PLACE OF DEATH:
County: Queen Anne
City or town: Kent & Queen Anne Hospital
(If outside city or town limits, write RURAL and give nearest town)
Chestertown
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Queen Anne
City or town: Price
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Mary Geneva Wheeler

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Col	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 15-1928

8. AGE:

Years	Months	Days	If less than one day
17	5	15	hrs. min.

9. Birthplace: Price Md.
(Town, county, and state)

10. Usual occupation: House work

11. Industry or business:

FATHER
12. Name: Chas. Wheeler
13. Birthplace: Md.

MOTHER
14. Maiden name: Olivia Brown
15. Birthplace: Md.

16. Informant: Chas Wheeler (Father)
Address: Price, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 4-45 (month) (day) (year)
Cemetery or crematory: Barclay
Location: Barclay Md
18. Funeral director: Edgar L. Lane
Address: Church Hill Md

19. Nov. 3 1945 (Date rec'd by registrar) Clara L. Barnes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 30. 1945 at 6 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Rupture of Liver	
Rupture of Kidney - Head injury	
Due to From fractured skull - all caused	
Due to Auto accident	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of Oct. 29. 45
Where did injury occur? near Church Hill Md
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Auto. accident Injured at work?

23. SIGNATURE: W. Henry Fraker
Dep. Md. Examiner
M. D. or other
Address: Centreville Md Date signed 11/3/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

(M)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (186-01)

CERTIFICATE OF DEATH

1019 Reg. Dist. No. 201

1. PLACE OF DEATH:
County: Kent
City or town: Betterton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? all life
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Kent
City or town: Betterton
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME William Benjamin Wheeler

3.(b) Social Security Number 154-09-9167

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Sadie Brice Wheeler
8.(c) If alive, give age 67 years
7. Birth date of deceased (mo., day, yr.): June 2, 1878

8. AGE: Years 67 Months 4 Days 23 If less than one day ___ hrs. ___ min.

9. Birthplace: Betterton Kent Md (Town, county, and state)
10. Usual occupation: Waterman
11. Industry or business: Fishery
FATHER 12. Name: Benjamin Wheeler
13. Birthplace: Md
MOTHER 14. Maiden name: Cordelia Creery
15. Birthplace: Betterton, Md
16. Informant: Mrs Sadie Wheeler
Address: Betterton Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 28 45 (month) (day) (year)
Cemetery or crematory: Still Pond
Location: Still Pond Md
18. Funeral director: B R Fellows
Address: Still Pond Md
19. Oct 27 1945 (Date rec'd by registrar) J M Clark Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 25 1945, at 7:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ___ 19__ to ___ 19__ and that I last saw h___ alive on ___ 19__
Did not attend. Investigated. Death figured certificate. Deputy Med Ex.

Immediate cause of death: Fracture Skull — DURATION: 1 hr
Due to: Fall (Accident)
Due to:
Other conditions
(Include pregnancy within 3 months of death)
Major findings of operations: None
Date of op.
Autopsy results: No
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of: Oct 25/45
Where did injury occur? Betterton Kent Md (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) Public Place
Means of injury: Fell
Injured at work? No
23. Signature: Frank Hines Deputy Med Exam - Kent Co. M. D. or other
Address: Chestertown Md Date signed: Oct 26/45

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10195

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (92-2)

CERTIFICATE OF DEATH

★ Reg. Dist. No. 203

1. PLACE OF DEATH:

County: Kent

City or town: Rock Hall, Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, Institution, or street address where death occurred: —

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Kent

City or town: Rock Hall, Md

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Sharp St

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Gertrude Stevens Hillson

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Fem	Wh.	widowed

6.(b) Name of husband or wife: James B. Hillson

6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): May 6 1862

8. AGE: Years	Months	Days	If less than one day
83	5	16	..... hrs. ..... min.

9. Birthplace: Rock Hall, Md (Town, county, and state)

10. Usual occupation: housework

11. Industry or business: own home

FATHER — 12. Name: Wesley Stevens

FATHER — 13. Birthplace: Rock Hall, Md

MOTHER — 14. Maiden name: Emily Athey

MOTHER — 15. Birthplace: Rock Hall, Md

18. Informant: B. Hillson

Address: Rock Hall, Md.

17. Burial, ~~cremation, or removal~~ Which? Burial — Date thereof Oct 24 1945 (month) (day) (year)

Cemetery or ~~crematory~~: St Johns.

Location: Rock Hall Md.

18. Funeral director: Edgar L Lane.

Address: Edmonds Hill Md.

19. Oct 24 1945 (Date rec'd by registrar) — S. Elwood Burgard, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 22 19 45, at 8 40 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 19 45, to Oct 22 19 45 and that I last saw her alive on Oct 22 19 45.

Immediate cause of death	DURATION
Cerebral accident	
Hypertension	
Due to: Con Endo-Myocarditis	
Due to: arteriosclerosis	
Other conditions: —	

(Include pregnancy within 3 months of death)

Major findings of operations: — Date of op.

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: — Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work?

23. SIGNATURE: Albert A Burgard M. D. or other

Address: Rock Hall, Md Date signed 10/23/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15